PREPARING FOR
MEDICARE SECONDARY PAYER ISSUES
IN SETTLEMENT CONFERENCES

§ 1 The Settlement Conference: Being Prepared

Settlement and compromise are essential to any risk management endeavor. As such, the settlement conference is an essential tool to that process and is often the most productive parties to bring the case to closure. The same is true of claims involving Medicare beneficiaries or those nearing beneficiary status. The Medicare Secondary Payer (MSP) Act, however, requires a separate risk analysis within the context of the overall claim. Settlement conferences are rarely productive unless the parties are adequately prepared to address the MSP considerations presented. Adequate preparation requires parties to the predicate groundwork necessary to have meaningful discussions regarding such things as conditional payments, the Medicare set-aside allocation, attorney fees and administrations. All of these things, left undone, can defeat the finality that the parties seek through settlement.

Lost in the numbers is the time factor. As will be discussed, having a proposed Medicare set-aside allocation submitted for review by the Centers for Medicare and Medicaid Services (CMS) can be time consuming and unpredictable. However, doing so prior to settlement (**YES!...That is possible!)** is time well worth the investment and allows for negotiation with a greater degree of certainty.

While the total amount of consideration a party is willing to pay or receive is at the top of the list of considerations, Medicare beneficiaries, and those approaching Medicare eligibility, have specific unique considerations that must be addressed in advance to have a productive negotiation.

§ 2 Who, What and When of the MSP

The MSP is a collection of statutes that were enacted as part of the original introduction of Medicare in 1965. Medicare is considered a “secondary” payer to primary payers such as workers’ compensation carriers and non-group health plans (NGHP). Troubling is the fact that Medicare has been secondary to workers’ compensation since 1965 and

liability carriers since 1980. Yet, until 2001, little, if any consideration, was given to the potential risks created by ignoring the language of the MSP. With the introduction of electronic reporting requirements in 2007, any acceptance of a claim or settlements involving Medicare beneficiaries is reported to CMS within three months of the settlement. Referred to as "mandatory reporting" or "Section 111" reporting, CMS collects data concerning any "ongoing responsibility for medical" (ORM) or settlements (referred to as a TPOC – Total Payment Obligation to Claimant). This data includes several data points including dollar figures and diagnostic codes.

§ 2.1 Who: Medicare Beneficiaries, Medicare-eligible, Reasonably Anticipated

The MSP must be addressed with **Medicare beneficiaries** including those individuals who, while they might not be actual beneficiaries, are ***eligible***. The language of CMS' operational memoranda extend this further in the context of workers' compensation to include those it deems "reasonably anticipated to become Medicare beneficiaries within 30 months of settlement.

Reasonably anticipated includes:

1. The individual has applied for Social Security Disability Benefits; or
2. The individual has been denied Social Security Disability Benefits but anticipates appealing that decision; or
3. The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits; or
4. The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
5. The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

It should be noted that the "reasonably anticipated" verbiage has only been specifically identified by CMS in association with workers' compensation claims although in the vacuum of statutory silence, these factors can be helpful in a liability context as well.

§ 2.2 What: The Shifting of Responsibility for Payment of Medical Treatment

At the inception of Medicare in 1965, Medicare was considered to be the primary payer for Medicare beneficiaries with one very significant exception – workers' compensation. Added to that language was the modern version of the Medicare Secondary Payer Act -- a collection of statutory provisions codified during the 1980s with the intention of reducing federal health care costs. These Federal requirements are found in Section 1862(b) of the Social Security Act {42 USC Section 1395y(b)(5)} while the applicable regulations are found at 42 CFR Part 411 (1990). The statute was amended by the Omnibus Budget Reconciliation Act of 1989 and by the Medicare Prescription Drug Improvement, and Modernization Act of 2003.

By paying all or part of the settlement, the alleged tortfeasor demonstrates that it was "required or responsible" for making payments to Medicare beneficiaries in a manner consistent with 42 U.S.C. §1395y(b)(2)(B)(ii).

§ 2.3 When: Closure of Medical Benefits

Anytime parties are considering closing medical benefits on an accepted claim or resolving a claim where the medical treatment is an element of damages and the injured party is a Medicare beneficiary, Medicare's interests must be considered.

§ 3 Considering Medicare's Interests

Considering Medicare's interests requires examining their interests in two separate temporal contexts:

(1) medical expenses already incurred and paid by Medicare, which are known as conditional payments, and

(2) the possibility of future medical expenses yet to be incurred that would likely have been paid through the injured party's Medicare coverage. These are typically referred to as Medicare set-asides or "future allocations."

§ 3.1 Conditional Payments

For existing Medicare beneficiaries, Medicare may pay medical benefits without knowing the existence of workers' compensation or a liability case. Even when such cases have been reported, Medicare still has the authority to make payments for medical treatment. When the workers' compensation or a liability case exists, these are considered "conditional payments" and CMS may seek reimbursement of these payments. The law also allows for triple damages. The latest trend in case law also extends these rights to "Medicare Advantage" plans who have grown very aggressive in pursuing recovery.

(A) In general
Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that…

(ii) payment has been made or can reasonably expect to be made under a workmen's compensation law or plan of the United States or a State or under a liability insurance policy or plan (including a self-insured plan) or under no fault…
…An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Repayment required

(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT – The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as

determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Primary plans
A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received the Secretary may charge interest (beginning with the date of which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States
In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan….

- 42 U.S.C.§1395y(b)(2)(A)&(B) (2004)

Timing is essential in incorporating the conditional payment component into your overall resolution approach. Medicare is not set up to move quickly nor will CMS provide a "final" number until after your settlement is final.

You must determine:

(1) the amount for which CMS or the Medicare Advantage is seeking reimbursement;
(2) whether the amount is accurate; and
(3) how the amount will be resolved in the context of settlement.

Following notification of Medicare of possible conditional payments, CMS will issue a "Rights and Responsibilities" letter to the Medicare beneficiary and any carrier identified as a primary payer. Typically, within 65 days, an initial "Conditional Payment Letter" (CPL) will be automatically provided and sent to anyone attached to the claim. The CPL contains what CMS refers to as the "interim" amount identified as the medical claims associated with the injury and paid by Medicare.

The CPL may be provided to all parties associated with the claim so long as they have provided a valid Consent to Release Form executed by the Medicare beneficiary or, in the case of an insurance carrier, by a valid Proof of Representation. It contains the current conditional payment amount and a list of all expenses, including dates of services, provider, and CPT codes.

The Medicare beneficiary (or a beneficiary's attorney with a valid Consent to Release) can retrieve up–to-date conditional payment amounts from three sources:

1. MyMedicare.gov website.

2. By telephone using the "MSPRC Self Service Information Feature" (1-866-677-7220). The following information is necessary in order to use this self-service feature:
•Case identification number (found on all MSPRC correspondence)
•Beneficiary's date of birth
•First five letters of Beneficiary's last name as it appears on Medicare card
•Last 4 digits of Beneficiary's Social Security number (or full Medicare number)

3. CMS has also launched Medicare Secondary Payer Recovery Portal, more recently. The MSPRP web portal is available for anyone to access, upon enrollment, by uploading a valid Consent to Release or Proof of Representation to the active claim file. The web portal allows access to the most recent conditional payment information and provides the ability to upload documents, request updates, dispute items based on relatedness, and submit settlement information.

More often than not, the conditional payment search (CPS) is undertaken by a specialty vendor who has been asked to also put together a Medicare set-aside allocation.

It is important to review the CPL to determine if the amount is appropriate. While identification of conditional payments has improved significantly in the last ten years, CMS still routinely identifies payments unrelated to the injury for reimbursement. The primary ground for disputing a demand for reimbursement of a conditional payment is based upon "relatedness," which is the causal relationship of the medical treatment to the injury in the underlying claim. The demand letter from CMS/MSPRC will indicate the relevant dates of service and CPT codes. The parties should review both the dates of service and the CPT codes for relatedness to the claim.

CMS has authority under the law, 42 C.F.R. 411.28 to waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim. This is rarely exercised by CMS. There is also a process to request a compromise based upon hardship, including the beneficiary's present or future inability to pay, although these requests are also rarely granted. Appeal rights are specified in the final demand letter.

Medicare will typically demand reimbursement of any conditional medical payments made related to the alleged injury, regardless of liability. A best practice is to determine in the settlement agreement which party will be responsible for the payments. Again, CMS and the Medicare Secondary Payer Recovery Center (MSPRC) will not provide a "final demand" figure until after the settlement has been reached.

Medicare does allow for a reduction in the amount of its conditional payment lien if the amount of settlement is less than the lien. Under 42 C.F.R. § 411.37(d), Medicare will

generally reduce its recovery by procurement costs, with the total recovery not to exceed the amount of settlement. Medicare essentially takes the attorney's fees and costs off the top, and then demands the entire remaining amount of settlement, leaving no net recovery to the plaintiff.

Other options for resolution include the Fixed Percentage Payment option (available in liability settlements of $5,000.00 or less), as well as the Low Dollar Threshold (available for liability settlements of $300.00 or less), both of which are discussed below. Unfortunately, these options are of practically no help in most cases.

A North Carolina law firm, Teague Campbell, has an excellent simple to understand summary of the most recent legislative development impacting this area – The SMART ACT:

> The Strengthening Medicare and Repaying Taxpayers (SMART) Act was signed into law on January 10, 2013. One of the major goals of the SMART Act was to allow parties to determine the exact amount of the conditional payment lien before settlement. On September 20, 2013, CMS issued an interim final rule addressing the conditional payment web portal. The interim final rule became effective as of November 19, 2013. All systems and process changes to the web portal are to be implemented no later than January 1, 2016. Once all of the security has been implemented, the fully operational web portal will then allow all users full access, including diagnosis codes, provider names, dates of services, etc. However, CMS's position with regard to obtaining a final conditional payment demand prior to settlement is still otherwise unclear.
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> It is also important to determine whether any medical payments have been made by a Medicare Advantage Part C Plan. In Humana v. GlaxoSmithKline, the United Stated Court of Appeals, Third Circuit, held that Humana, a Medicare Advantage Part C Plan, had a private cause of action under 42 U.S.C. § 1395y(b)(3)(A) of the Medicare Secondary Payer Act, to sue tortfeasors for double damages based upon Medicare conditional payments. Significantly, such conditional payments made under Medicare Part C will not appear on any MSPRC conditional payment investigation or demand, but rather must be verified directly with the provider of the Part C plan. Additionally, the beneficiary's Medicare coverage is subject to change on an annual basis, and the Part C component may alternate to different providers, making identification of potential Part C conditional payments extremely tricky to verify.

It is essential to resolve conditional payments either through payment or assignment of risk at the time of settlement. All parties to the settlement are at risk for reimbursement in the absence of satisfaction.

§ 3.2 Future Interests: The Medicare Set-Aside Allocation

A Medicare set-aside is an arrangement that:

1) projects future medical and prescription expenses for treatment related to an injury or accident that would otherwise be payable by Medicare;

2) allocates those funds from a settlement or award; and

3) provides for administration of those funds. The object is to provide a structured and safe means for the parties to settle a claim while reasonably considering Medicare's future interest with respect to future medical benefits.

It may take the form of a self-administered Medicare set-aside arrangement, a Medicare set-aside custodial account, or a more formal Medicare set-aside trust.

The following information is typically required for review:

(1) Reviewing the Entire Medical History of the Claim. While the focus of the MSA narrative will be on the most recent two years, it is essential to have the entire medical history of the claim in order to recognize treatment trends and project future options that may be pursued.

(2) Reviewing the Payment Ledger for the Entire History of the Claim. Similar to the medical history, this will provide the basis for payment trends and analysis of past costs with the emphasis being placed on the last two years. The ledgers should include all indemnity, medical and pharmacy payments made.

(3) Reviewing Basic Injury/Accident Information. This includes all identifying information relevant to the claimant/plaintiff, insurer, counsel, diagnoses (accepted/denied; related /unrelated); jurisdiction, nature of claim (workers' compensation versus liability).

Medical records are then analyzed to assemble the future medical allocation. It is good practice to identify the most comprehensive reports and those reports such as IMEs that will provide well documented medical histories. From those records, a summary of the related medical conditions is created as well as concurrent unrelated conditions, procedure and diagnostic codes. Specific treatment that occurs is documented individually. The goal is to create a comprehensive summary of the substantive medical treatment that specifically identifies each type of visit, test, treatment, invasive procedure and diagnosis present in the medical record. If the records include common periodic treatment such as often occurs with physical therapy or chiropractic treatment, the preparer should also note the annual frequency of such visits, i.e., how many chiropractic treatments occurred in 2014, etc.

The basis for the projection is typically based on a trio of considerations. Specifically, each individual projection should be based upon:

(i) Physician's Recommendation: In this case, there should be a specific medical note identifying the recommended treatment. Be careful that the note is not outdated or an alternative course of treatment followed.

(ii) Pattern of Treatment: CMS often views past utilization of services as indicative of future treatment needs. As a result, frequent references to specific treatment in notes

or in the payment history will often trigger those services being repeated over a long period of time absent documentation to the contrary.

(iii) Standard of Care: This particular basis is often not well-documented in the records but usually consists of recurring diagnostic or preventative services such as periodic MRIs or X-rays or lab work necessary to monitor the effect of medications**.**

So who does all this? **Professional Vendors!!**

Expect to pay between $2,200 and $3,500 for a Medicare set-aside allocation and conditional payment search. If the MSA is submitted for review and approval by CMS, typically the charge is an additional $1,000.

§ 3.3 Administration of the Medicare Set-Aside

An essential element of any Medicare set-aside allocation is the administration of the funds. CMS poses few requirements for administration but even those minimum requirements creates concern and future issues for those individuals ill-equipped to manage funds. The three basic rules for administration are that the funds in the WCMSA may only be used to pay for (1) future medical and prescription drug expenses; (2) for treatment of the claimant's work- or injury-related conditions; and (3) for treatment of the type normally covered by Medicare. When evaluating the services, remember the "first rule:" Medicare covers services that reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Nearly all MSAs are self-administered and it's generally thought that most are managed incorrectly. Fortunately, the CMS machinery is not currently equipped to address these shortfalls. Three basic options exist but the latter two options involve expenses that must be borne by one or both parties to the settlement.

A primary source of irritation for administration is paying the appropriate amount to providers and only using the funds for injury-related care. An individual is NOT limited to the treatment identified in the allocation but is limited by the pricing methodology. Workers' compensation MSAs are allocated using the workers' compensation fee schedule for the state in which the claim resided – usually about 20-30% less than usual and customary charges. Providers may refuse to accept the reduced fee schedule amount but can sometimes be persuaded to accept Medicare rates. There is also some cushion available with the pharmacy projection as it utilizes average wholesale prices which are typically higher.

Self-Administration
Self-administration is just that – the claimant or plaintiff administers his or her own funds in a manner consistent with CMS requirements. There are multiple pitfalls that can result in even a conscientious claimant or plaintiff falling short of meeting the requirements. Doing so will manifest the time of depletion when it must be demonstrated that the money was spent appropriately.

Self-Administration with Support
The funds are essentially self-administered but services are purchased designed to provide beneficiaries with the knowledge, forms and resources necessary to self-administer a Medicare Set-Aside (MSA) account

Professional Administration
A professional administrator will typically prepare the Medicare Set Aside Trust/custodial agreement, establish the set aside trust/account, audit medical bills for cost containment, communicate with medical providers and negotiate bills, pay Medicare covered services from the MSA trust/account, advise CMS of temporary exhaustion of funds resulting in Medicare becoming primary coverage and provide a professional to CMS regarding the expenditures from the Medicare Set-aside.

§ 4 Tools for Finding Value in the Medicare Set-Aside process

When incorporating the Medicare set-aside into the negotiation process, recognize that the funds that are used to fund the allocation are not available for discretionary spending on non-Medicare covered items or non-medical items such as attorney fees. As a result, the MSA can take a significant amount of money out of play in the negotiation process and frustrate the overall progress. In order to reach the goal of resolution, parties need to recognize the true cost of the "allocation" as opposed to the portion of the settlement that ends up in the claimant or plaintiff's "pocket."

There are multiple tools for trying to identify the lowest possible MSA allocation that can be defended and presumably allow for greater consideration to be shifted to the pocket side of the settlement.

(1) Audit the Medical Projection: The medical projection should be limited to only Medicare-covered treatment that is supported by the medical records. If a medical need is not covered by Medicare (example: domiciliary care, nursing home care), consideration can be obtained outside the MSA.

- Identify non-Medicare covered costs;
- Is it supported by the medical documentation;
- Can you obtain medical documentation from the provider limiting the future costs?

(2) Audit the Pharmacy Projection: Pharmacy costs are the primary cost driver in nearly every MSA. CMS compounds this problem by insisting on an unreasonable pricing methodology. While medical treatment is projected using fee schedules (workers' compensation) or usual and customary (liability), pharmacy projections utilize the average wholesale price as published in the Red Book. This is typically the highest price typically associated a medication.

- Is the medication covered by Medicare?
- Generic versus brand-name;
- Is projection consistent with actual prescription regimen?
- Can the dosages be altered without altering the total? (EX: Gabapentin 600 mg vs. 200 mg x 6)
- Can a medication be tapered?
- Would a drug utilization review (DUR) be helpful?

(3) Obtain a Rated Age: MSA projections are intended to reflect the medical and pharmacy costs for the lifetime of the claimant or plaintiff. High annual prescription costs for expensive drugs that are not typically prescribed for a lifetime can skyrocket the costs of a projection. Similarly, CMS will expect projections for replacement of spinal cord stimulators on a periodic basis in addition to anticipating additional replacements for total arthroplasties of knees and hips. By utilizing a rated age, the duration of the projection can typically be reduced by one to eight years. In the event of significant co-morbidities such as cancer, renal disease, asbestosis, etc., the reductions available through the rated age are significant.

(4) Use an Annuity or other Structured Settlement: While a portion of the MSA (the "seed" money) must be deposited immediately into an interest-bearing account, the remainder of the MSA projection can be funded via an annuity. The "seed" money is composed of the first surgery or implantation plus the first two years of annual projected costs. Annuities present a significant financial opportunity, particularly for projections are of high duration. A single annuity can be utilized for both medical and pharmacy projections or split out as the economics dictate.

Annuities can also be used to pay attorney fees or provide additional consideration that goes straight into the pocket of the claimant/plaintiff. The use of an annuity does require some thought to be given how depletions of the MSA would be handled in the event that medical costs exceed the amount available in the account.

§ 5 Conclusion

MSP issues, left unaddressed, will delay or derail settlement. Productive mediation requires an early start so that you arrive at the mediation with certainty regarding the

Medicare Secondary Payer issues. This includes knowing the value of the conditional payments, having an MSA in hand and possibly even submitting the matter for approval in advance of mediation.

Parties should invest in the services of a professional vendor responsive to the needs of the customer and cognizant of the issues peculiar to the case. Only by understanding the details of the MSP issues will you be able to obtain the best result from your vendor and your case.

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Prior to forming Montana Work Comp Solutions in late 2014, he worked as a Special Assistant Attorney General providing representation to the Montana State Fund. Prior to joining the Montana State Fund in 2006, he owned and operated The Blackaby Law Firm, P.C. and The Montana Work Comp Law Center for more than ten years specializing in the representation of injured workers (1996-2006). He has lectured frequently on the topic of the Medicare Secondary Payer Act, workers' compensation including presentations before such groups as the Montana Trial Lawyers Association, the California Applicants' Attorneys Association and the Arizona Association for Justice.

Mr. Blackaby is a 1992 graduate of the University of Missouri-Kansas City School of Law. He is a member of The Montana Bar and the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and is a Medicare Set-Aside Consultant-Certified (MSCC).

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